Dr. John H. Lee & Associates 에 오신 것을 환영합니다

성함 Name:	금일 Today's date:
주소 Address:	성별 Sex: 남 M 여 F 결혼여부 Marital Status:
시/주/우편번호 City/State/Zip:	생년월일 Date of Birth: 나이 Age:
전화번호 Phone #s: 자택 Home:	사회 보장 번호 Social Security Number:
핸드폰 Cell:	고용주 Employer: 직업 Occupation:
직장 Work:	이메일 Email:

1 차 진료의/주치의 Primary Care Physician:	전화번호 Phone#:	마지막 검진일 Last seen:
과거 안과의사/검안의 Previous Eye Doctor:	마지막 검진일 Last seen:	

과거에 안경을 쓰신적이 있으십니까? Have you ever worn glasses Y N

지금도 안경을 쓰십니까? Do you still wear them? Y N

안경을 쓰시는 용도: Uses for glasses:

☐항상 Always ☐컴퓨터 Computer ☐독서 Reading

☐운전 Driving ☐보안 Safety ☐운동 Sports

☐햇빛 Sun ☐콘텍트렌즈 대체 Back up to contact lenses

콘텍트 렌즈 구매여부 Interested in contact lenses? Y N

과거 콘텍트렌즈 착용여부 Have you ever worn them? Y N

현재 콘텍트렌즈 착용여부 Do you still wear them? Y N

If yes: 콘텍트렌즈 타입 Type of contacts:

교체시기 Replacement Schedule:

렌즈 세척액 Cleaning System:

이하 질병 증상을 과거에 지니셨거나 현재 지니고 계십니까? Y N 해당되는 모든 증상에 표기하십시오. Check all that apply:

☐ 눈 감염 Eye Infection ☐백내장 Cataracts ☐망막 박리 Retinal Detachment ☐ 눈부상 Eye Injury: R / L

☐ 사시 Crossed/Lazy Eyes ☐황반변 Macular Degeneration ☐맹목 Blindness ☐ 기타 Other:

☐당뇨 Diabetes ☐각막 마모 Corneal Abrasion ☐원추 각막 Keratoconus

☐녹내장 Glaucoma ☐궤양 Ulcer ☐ 눈 수술 Eye Surgery (specify):

이하와 같은 가족 병력이 있으십니까? 해당되는 모든 증상에 표기하십시오.

☐백내장 Cataracts ☐ 녹내장 Glaucoma ☐맹목 Blindness ☐황반변 Macular Degeneration

☐ 사시 Crossed/Lazy Eyes ☐ 기타 Other: 관계 Relationship: ☐ 해당사항 없음 None

다음과 같은 문제를 가지고 있습니까?

Yes	No		Yes	No	
☐	☐	없음 No Problems	☐	☐	이물감 Foreign Body Sensation
☐	☐	흐린 시야 Blurred Vision	☐	☐	눈처짐 Droopy Lids
☐	☐	야간 운전시 어려움/눈 부심 Difficulty Driving at Night / Glare	☐	☐	비문증 Spots or Floater - new? Or increase?
☐	☐	복시 Double Vision	☐	☐	빛보임 Seeing Light Flashes
☐	☐	시력손상 Loss of Vision or Side vision	☐	☐	눈부심/광선 혐기증 Increased Light Sensitivity
☐	☐	적안 Red Eyes	☐	☐	안구건조 Dry Eyes
☐	☐	눈 가려움/화상 Eyes itch / burn / both	☐	☐	두통 Headaches: 발병빈도 how often?
☐	☐	눈물 Eyes water / tear / discharge			위치 where?
☐	☐	눈 주위 통증 Pain in / around eyes	☐	☐	기타 Other:

이하와 같은 본인 또는 가족 병력/증상이 있으시면 표기하십시요. 이하 정보는 저희가 귀하에게 최상의 진료를 제공하는데 도움이 될 것 입니다. 본 자료는 진료 용도 이외에 다른 목적으로 사용되지 않습니다.

본인 Yes	본인 No	가족 Yes	가족 No		본인 Yes	본인 No	가족 Yes	가족 No	
☐	☐	☐	☐	고혈압 High Blood Pressure	☐	☐			계절성 알러지 Seasonal Allergies
☐	☐	☐	☐	당뇨 Diabetes - Last A1C:_____	☐	☐	☐	☐	순환기 장애 Circulation Problems
☐	☐	☐	☐	고 콜레스트롤/심장병 Hi Chol/Heart Dis	☐	☐	☐	☐	호흡곤란/천식 Respiratory Prob/Asthma
☐	☐	☐	☐	낫형적혈구빈혈증 Sickle Cell Anemia	☐	☐	☐	☐	약물 의존 Chemical Dependency
☐	☐	☐	☐	갑상선 질환 Thyroid Disease	☐	☐			우울/불안 Depression/Anxiety
☐	☐	☐	☐	자가면역질환 Auto Immune Disorder	☐	☐			간염 Hepatitis (Type:_____)
☐	☐	☐	☐	다발성 경화증 Multiple Sclerosis	☐	☐			임신 혹은 수유 유무 Pregnant or Nursing
☐	☐	☐	☐	암 Cancer (specify):	☐	☐			에이즈/HIV 보균자 AIDS/HIV Positive
☐	☐	☐	☐	유육종증 Sarcoidosis	☐	☐			감염질환 Infectious Dis (List:_____)
☐	☐	☐	☐	흡연/음주 Tobacco / Alcohol use	☐	☐	☐	☐	기타 Other:

현재 복용하시는 약이 있습니까? 처방제또는 비처방약 등을 기재하십시오:

약물 또는 점안액 알러지가 있으시면 기재하십시요

위의 내용 외에 의사와 상담할 내용이 있으십니까?

어떻게 저희 병원을 찾으셨나요?

Patient Name (If patient is under 18, the name of the responsible party): _____

I acknowledge that I will be a self-paid patient today. That means that I will be paying my balance today in full at the time of service. I will not be sending in a claim to an insurance company of which this practice is already a provider.

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

INSURANCE INFORMATION AND RELEASE OF INFORMATION

In the event that your insurance does not pay for the services provided in our office, you will be responsible for any unpaid balances. Verification of vision coverage does not guarantee insurance company payment. Payment is based on actual coverage and policy determination upon receipt of the claim for the date of service. It is also your responsibility to know and understand any deductible or co-insurance payments your plan has that you will be responsible to pay. Please provide the following information that is necessary so that we are able to process your claim.

PATIENT NAME	PATIENT DATE OF BIRTH	PATIENT SOCIAL SECURITY #
POLICY HOLDER NAME	POLICY HOLDER DATE OF BIRTH	HOLDER SOCIAL SECURITY #
		CHILD SPOUSE SELF
POLICY HOLDER'S EMPLOYER		PATIENT RELATIONSHIP TO POLICY HOLDER (CIRCLE)
VISION PLAN NAME	VISION PLAN ID#	GROUP #
MEDICAL INSURANCE NAME	MEDICAL INS ID#	GROUP #
SECONDARY MEDICAL INSURANCE NAME	SECONDARY MED INS ID#	GROUP #

I, _____, have read the above, and understand that I am responsible for any balance that my insurance company does not pay. I am also acknowledging that all of the information I have provided is accurate and correct. I understand that failure to provide the most accurate and true information will result in my claim being denied. I am also acknowledging that I agree to release all necessary medical and demographic information from my records at this office to my insurance company.

_____ _____

SIGNATURE OF PATIENT OR PERSON RESPONSIBLE FOR PATIENT'S BILL DATE

OFFICE USE ONLY		
AUTHORIZATION # REE:	CLFITTING:	CLS:
ELIGIBILITY VERIFIED VIA (CIRCLE): FAX INTERNET	PHONE (VERIFIER'S NAME:	)
ELIG FOR EXAM: Y N	ELIG FOR CLFIT: Y N	ELIG FOR CLS ALLOWANCE: Y N
COPAY:	COPAY:	COPAY: